Aetna Student Health

Aetna PPO Dental Plan Design and Benefits Summary

Policy Year: 2017-2018
Policy Number: 883998
This Aetna Dental® Preferred Provider Organization (PPO) insurance plan summary is provided by Aetna Life Insurance Company (Aetna) for some of the more frequently performed dental procedures. Under this plan, you may choose at the time of service either a PPO participating dentist or any nonparticipating dentist. With the PPO plan, savings are possible because the PPO participating dentists have agreed to provide care for covered services at the negotiated fee schedule.

**Coverage Periods**

**Students:**

Coverage for eligible students will become effective at or after 12:00 a.m. on the coverage dates indicated on the Master Policy, and will terminate at or before 11:59 p.m. on the coverage dates on the Master Policy.

**Eligible Dependents:**

Coverage will become effective on the same date the insured student's coverage is effective. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy.

**Rates**

The cost for the Emory University Dental Plan is included in the premium rates displayed on page six (6) of the 2017/2018 Emory University Plan Design and Benefits Summary which can be located online at [www.aetnastudenthealth.com/](http://www.aetnastudenthealth.com/).

**Eligibility**

**Student Coverage**

All members enrolled in the Emory University Student Health Insurance Plan.

Home study, correspondence, Internet classes, and television (TV) courses, do not fulfill the eligibility requirement that the student actively attend classes. If it is discovered that this eligibility requirement has not been met, our only obligation is to refund premium, less any claims paid.

**Dependent Coverage**

All eligible dependents enrolled in the Emory University Student Health Insurance Plan.
Preferred Provider Network

Consult Aetna Dental online provider directory, DocFind®, for the most current provider listings. Preferred providers are independent contractors in private practice and are neither employees nor agents of Aetna. The availability of any particular provider cannot be guaranteed. Provider participation may change without notice. Aetna does not provide care or guarantee access to dental services. For the most current information, please contact the selected provider or Aetna Member Services at the toll-free number on your ID card, or use our Internet-based provider directory (DocFind) available at www.aetna.com.

Payment made to a PPO provider is based on a negotiated charge, which is usually significantly less than the providers’ standard billed charges. PPO providers cannot bill beyond the negotiated charge for covered services.

Non-preferred benefits are also subject to recognized charge limits.

To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage to use a Preferred Provider because savings may be achieved from the Negotiated Charges these providers have agreed to accept as payment for their services.

In the event of a problem with coverage, members should contact Member Services at the toll-free number on their ID cards for information on how to utilize the grievance procedure when appropriate.

All member care and related decisions are the sole responsibility of preferred providers. Aetna dental does not provide health care services and, therefore, cannot guarantee any results or outcomes.

Description of Benefits

The Plan excludes coverage for certain services and contains limitations on the amounts it will pay. While this Plan Design and Benefits Summary document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. To look at the full Plan description, which is contained in the Master Policy issued to Emory University, please contact Aetna Student Health at (877)-238-6200. If any discrepancy exists between this Benefit Summary and the Policy, the Master Policy will govern and control the payment of benefits.

*All coverage is based on Recognized Charges unless otherwise specified.

<table>
<thead>
<tr>
<th>Policy Year Maximum</th>
<th>$1,000</th>
</tr>
</thead>
</table>

**Policy Year Maximum:** The most the plan will pay for covered expenses incurred by any one covered person in a policy year is called the Policy Year Maximum Benefit.

The policy year maximum benefit applies to preferred and non-preferred covered dental expenses combined.
DEDUCTIBLE*
*The policy year deductible applies to all covered expenses except Type A Expenses (Preventative & Diagnostic Care)

<table>
<thead>
<tr>
<th></th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual:</td>
<td>$50</td>
<td>$50</td>
</tr>
<tr>
<td>Family:</td>
<td>$150</td>
<td>$150</td>
</tr>
</tbody>
</table>

Deductible Carryover: Covered Expenses incurred during the last three months of a policy year that applied to this policy year’s deductible also apply to the following year’s deductible.

<table>
<thead>
<tr>
<th></th>
<th>Preferred Care</th>
<th>Non-Preferred Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type A: Diagnostic and Preventative Services</td>
<td>100% of the negotiated charge</td>
<td>100% of the recognized charge</td>
</tr>
<tr>
<td>Type B Expenses: Basic Restorative Care</td>
<td>80% of the negotiated charge</td>
<td>80% of the recognized charge</td>
</tr>
<tr>
<td>Type C Expenses: Major Restorative Care</td>
<td>50% of the negotiated charge</td>
<td>50% of the recognized charge</td>
</tr>
</tbody>
</table>

ORTHODONTICS
Not Covered
Not Covered

Description of Covered Service by Benefit Service Category

Type A Expenses: Diagnostic and Preventive Care Covered Services

Visits and X-Rays
- Office visit during regular office hours; for oral examination (limited to 2 visits every year)
- Prophylaxis (cleaning) (limited to 2 treatments per year) Adult Child
- Topical application of fluoride; (limited to 1 course of treatment per year and to children under age 14)
- Sealants; per tooth (limited to 1 application every 5 years for permanent bicuspids and molars only; and to children under age 14)
- Bitewing X-rays (limited to 1 set per year)
- Entire denture series consisting of at least 14 films; including bitewings if necessary; or panoramic film limited to 1 set every 5 years

Type B Expenses: Basic Restorative Care Covered Expenses

Visits and X-Rays
- Professional visit after hours (payment will be made on the basis of services rendered or visit; whichever is greater)
- Emergency palliative treatment; per visit

X-Ray and Pathology
- Periapical x-rays (single films up to 13)
- Intra-oral; occlusal view; maxillary or mandibular
- Upper or lower jaw; extra-oral
- Biopsy and histopathologic examination of oral tissue
<table>
<thead>
<tr>
<th>Type B Expenses: Basic Restorative Care Covered Expenses (continued)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Oral Surgery</strong></td>
</tr>
<tr>
<td>• Extractions</td>
</tr>
<tr>
<td>• Exposed root or erupted tooth</td>
</tr>
<tr>
<td>• Surgical removal of erupted tooth</td>
</tr>
<tr>
<td>• Impacted Teeth</td>
</tr>
<tr>
<td>• Removal of tooth (soft tissue)</td>
</tr>
<tr>
<td>• Odontogenic Cysts and Neoplasms</td>
</tr>
<tr>
<td>o Incision and drainage of abscess</td>
</tr>
<tr>
<td>o Removal of odontogenic cyst or tumor</td>
</tr>
<tr>
<td>• Other Surgical Procedures</td>
</tr>
<tr>
<td>o Alveoplasty; in conjunction with extractions - per quadrant</td>
</tr>
<tr>
<td>o Alveoplasty; not in conjunction with extraction - per quadrant</td>
</tr>
<tr>
<td>o Sialolithotomy: removal of salivary calculus</td>
</tr>
<tr>
<td>o Closure of salivary fistula</td>
</tr>
<tr>
<td>o Excision of hyperplastic tissue</td>
</tr>
<tr>
<td>o Removal of exostosis</td>
</tr>
<tr>
<td>o Transplantation of tooth or tooth bud</td>
</tr>
<tr>
<td>o Closure of oral fistula of maxillary sinus</td>
</tr>
<tr>
<td>o Sequestrectomy</td>
</tr>
<tr>
<td>o Crown exposure to aid eruption</td>
</tr>
<tr>
<td>o Removal of foreign body from soft tissue</td>
</tr>
<tr>
<td>o Frenectomy</td>
</tr>
<tr>
<td>o Suture of soft tissue injury</td>
</tr>
<tr>
<td><strong>Periodontics</strong></td>
</tr>
<tr>
<td>• Occlusal adjustment (other than with an appliance or by restoration)</td>
</tr>
<tr>
<td>• Root planning and scaling; per quadrant (limited to 4 separate quadrants every 2 years)</td>
</tr>
<tr>
<td>• Root planning and scaling – 1 to 3 teeth per quadrant (limited to once per site every 2 years)</td>
</tr>
<tr>
<td>• Gingivectomy; per quadrant (limited to 1 per quadrant every 3 years)</td>
</tr>
<tr>
<td>• Gingivectomy; 1 to 3 teeth per quadrant; limited to 1 per site every 3 years</td>
</tr>
<tr>
<td>• Gingival flap procedure - per quadrant (limited to 1 per quadrant every 3 years)</td>
</tr>
<tr>
<td>• Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)</td>
</tr>
<tr>
<td>• Periodontal maintenance procedures following active therapy (limited to 2 per year)</td>
</tr>
<tr>
<td>• Localized delivery of chemotherapeutic agents</td>
</tr>
<tr>
<td><strong>Endodontics</strong></td>
</tr>
<tr>
<td>• Pulp cap</td>
</tr>
<tr>
<td>• Pulpotomy</td>
</tr>
<tr>
<td>• Apexification/recalcification</td>
</tr>
<tr>
<td>• Apicoectomy</td>
</tr>
<tr>
<td>• Root canal therapy including necessary X-rays</td>
</tr>
<tr>
<td>o Bicuspid Anterior</td>
</tr>
<tr>
<td>o Bicuspid</td>
</tr>
</tbody>
</table>
Type B Expenses: Basic Restorative Care Covered Expenses (continued)

Restorative Dentistry Excludes inlays; crowns (other than prefabricated stainless steel or resin) and bridges. (Multiple restorations in 1 surface will be considered as a single restoration.)
- Amalgam restorations
- Resin-based composite restorations (other than for molars)
- Pins
- Pin retention—per tooth; in addition to amalgam or resin restoration
- Crowns (when tooth cannot be restored with a filling material)
- Prefabricated stainless steel
- Prefabricated resin crown (excluding temporary crowns)
- Recementation
  - Inlay
  - Crown
  - Bridge

Type C Expenses: Major Restorative Care Covered Services

Oral Surgery
- Impacted Teeth
  - Removal of tooth (partially bony)
  - Removal of tooth (completely bony)

Periodontics
- Osseous surgery (including flap and closure); 1 to 3 teeth per quadrant; limited to 1 per quadrant; every 5 years
- Osseous surgery (including flap and closure); per quadrant; limited to 1 per site; every 5 years
- Soft tissue graft procedures

ENDODONTICS
- Root canal therapy including necessary X-rays
- Molar

Restorative  Inlays; onlays; labial veneers and crowns are covered only as treatment for decay or acute traumatic injury and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge (limited to 1 per tooth every 10 years- see Replacement Rule)
- Inlays/Onlays-Metallic or Porcelain/Ceramic
  - Inlay; 1 or more surfaces
  - Onlay; 2 or more surfaces
- Inlays/Onlays-Resin-based composite
  - Inlay; 1 or more surfaces
  - Onlay; 2 or more surfaces
- Labial Veneers
  - Laminate-chairside
  - Resin laminate – laboratory
  - Porcelain laminate – laboratory
- Crowns
**Type C Expenses: Major Restorative Care Covered Services (continued)**

- **Resin**
  - Resin with noble metal
  - Resin with base metal
- **Porcelain**
  - Porcelain with noble metal
  - Porcelain with base metal
- **Base metal (full cast)**
- **Noble metal (full cast)**
- **Metallic (3/4 cast)**
- **Post and core**

**Prosthodontics:** First installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 10 years old. (See Tooth Missing But Not Replaced Rule.) Replacement of existing bridges or dentures is limited to 1 every 10 years. (See Replacement Rule.)

- **Bridge Abutments (See Inlays and Crowns)**
- **Pontics**
  - Base metal (full cast)
  - Noble metal (full cast)
  - Base metal (full cast)
  - Porcelain with noble metal
  - Porcelain with base metal
  - Resin with noble metal
  - Resin with base metal
- **Removable Bridge (unilateral)**
  - One piece casting; chrome cobalt alloy clasp attachment (all types) per unit; including pontics
- **Dentures and Partial (Fees for dentures and partial dentures include relines; rebases; and adjustments; within 6 months after installation.**
  - Fees for relines and rebases include adjustments within 6 months after installation.
  - (Specialized techniques and characterizations are not eligible.)
    - Complete upper denture
    - Complete lower denture
    - Partial upper or lower; resin base (including any conventional clasps; rests and teeth)
    - Partial upper or lower; cast metal base with resin saddles (including any conventional clasps; rests and teeth)
- **Stress breakers**
- **Interim partial denture (stayplate); anterior only**
- **Office reline**
  - Laboratory reline
  - Special tissue conditioning; per denture
  - Rebase; per denture
  - Adjustment to denture more than 6 months after installation
### Type C Expenses: Major Restorative Care Covered Services (continued)

- Full and partial denture repairs
- Broken dentures; no teeth involved
- Repair cast framework
- Replacing missing or broken teeth; each tooth
- Adding teeth to existing partial denture
  - Each tooth
  - Each clasp
- Repairs: crowns and bridges
- Occlusal guard (for bruxism only); limited to 1 every 5 years

### SPACE MAINTAINERS:
Only when needed to preserve space resulting from premature loss of deciduous teeth. (Includes all adjustments within 6 months after installation.)

- Fixed (unilateral or bilateral)
- Removable (unilateral or bilateral)
- Removable inhibiting appliance to correct thumbsucking
- Fixed or cemented inhibiting appliance to correct thumbsucking

### GENERAL ANESTHESIA AND INTRAVENOUS SEDATION
(only when provided in conjunction with a covered surgical procedure)

---

**Emergency Dental Care***

If you need emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week. When emergency services are provided by a participating PPO dentist, your coinsurance amount will be based on a negotiated fee schedule. When emergency services are provided by a non-participating dentist, you will be responsible for the difference between the plan payment and the dentist’s usual charge.

Subject to state requirements: Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

*Covered emergency services may vary, based on state law.*
Exclusions

Not every dental care service or supply is covered by the plan, even if prescribed; recommended; or approved by the covered person’s physician; or dentist. The plan covers only those services and supplies that are included in the Dental Care Schedule. Charges made for the following are not covered. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered; or are subject to special limitations.

1. Apicoectomy (dental root resection); root canal treatment.

2. Cosmetic services and supplies including plastic surgery; reconstructive surgery; cosmetic surgery; personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance; augmentation and vestibuloplasty; and other substances to protect; clean; whiten; bleach; or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the Dental Care Schedule.

3. Crown; inlays and onlays; and veneers unless:
   • It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
   • The tooth is an abutment to a covered partial denture or fixed bridge.

4. Dental implants; false teeth; prosthetic restoration of dental implants; plates; dentures; braces; mouth guards; and other devices to protect, replace or reposition teeth and removal of implants.

5. Services and supplies provided for the covered person’s personal comfort or convenience, or the convenience of any other person, including a provider.

6. Services or supplies furnished by a network provider in excess of such provider’s negotiated charge for that service or supply.

7. Services and supplies provided in connection with treatment or care that is not covered under the plan.

8. Space maintainers; except when needed to preserve space resulting from the premature loss of deciduous teeth.

9. Dental services and supplies that are covered in whole or in part:
   • Under any other part of this plan; or
   • Under any other plan of group benefits provided by the policyholder.

10. Dentures; crowns; inlays; onlays; bridges; or other appliances or services used for the purpose of splinting; to alter vertical dimension; to restore occlusion; or correcting attrition; abrasion; or erosion.

11. First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth; or to replace teeth; all of which were lost while the covered person was not covered.

12. Any instruction for diet; plaque control; and oral hygiene.
13. General anesthesia and intravenous sedation; unless specifically covered and only when done in connection with another medically necessary covered service or supply.

14. Except as covered in the Dental Care Schedule section, non-surgical surgical treatment of any jaw joint disorder. and treatments to alter bite; or the alignment or operation of the jaw; including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

15. Orthodontic treatment, except as covered in the Dental Care Schedule.

16. Pontics; crowns; cast or processed restorations; made with high noble metals (gold or titanium).

17. Prescribed drugs; pre-medication; or analgesia.

18. Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.


20. Surgical removal of impacted wisdom teeth when only for orthodontic reasons.

21. Treatment by other than a dentist. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a dentist. These are:
   - Scaling of teeth; and
   - Cleaning of teeth.

22. Treatment of alveolectomy.

23. Treatment of periodontal disease.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.
Your Dental Care Plan Coverage Is Subject to the Following Rules

Several rules apply to the dental plan. Following these rules will help the covered person to use the plan to their advantage by avoiding expenses that are not covered by the plan. **Replacement Rule**

Crowns, inlays and onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the plan’s replacement rule. That means certain replacements of, or additions to, existing dentures or bridges are covered only when the **covered person** provides proof to Aetna that:

- While covered by the plan, the covered person had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, the covered person needed to replace or add teeth to their denture or bridge.
- The present crown, inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least 10 years before its replacement and cannot be made serviceable.
- The covered person had a tooth (or teeth) extracted while they were covered by the plan. The covered person’s present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

**Tooth Missing But Not Replaced Rule**

The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges or other prosthetic services are needed to replace one or more natural teeth that were removed while the covered person is covered by the plan; and
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 10 years. The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

**Alternate Treatment Rule**

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When alternate services or supplies can be used, the plan’s coverage will be limited to the cost of the least expensive service or supply that is:

- Customarily used nationwide for treatment, and
- Deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account the covered person’s current oral condition.

The covered person should review the differences in the cost of alternate treatment with their dental provider. The covered person and their dental provider can still choose the more costly treatment method. The covered person is responsible for any charges in excess of what the plan will cover.
**Coverage for Dental Work Begun Before The Covered Person is Covered by the Plan**

The plan does not cover dental work that began before the covered person was covered by the plan. This means that the following dental work is not covered:

- An appliance, or modification of an appliance, if an impression for it was made before the covered person was covered by the plan;
- A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before the covered person was covered by the plan; or
- Root canal therapy, if the pulp chamber for it was opened before the covered person was covered by the plan.

**Coverage for Dental Work Completed After Termination of Coverage**

Dental coverage may end while the covered person is in the middle of treatment. The plan does not cover dental services that are given after the coverage terminates. There is an exception. The plan will cover the following services if they are ordered while the covered person was covered by the plan, and installed within 30 days after the coverage ends.

- Inlays;
- Onlays;
- Crowns;
- Removable bridges;
- Cast or processed restorations;
- Dentures;
- Fixed partial dentures (bridges); and
- Root canals.

"Ordered" means:

- For a denture: the impressions from which the denture will be made were taken.
- For a root canal: the pulp chamber was opened.
- For any other item: the teeth which will serve as retainers or supports, or the teeth which are being restored:
  - Must have been fully prepared to receive the item; and
  - Impressions have been taken from which the item will be prepared.

The Emory University Dental® Preferred Provider Organization (PPO) Student Dental Plan is underwritten and administered by Aetna Life Insurance Company (ALIC). Aetna Student Health℠ is the brand name for products and services provided by these companies and their applicable affiliated companies.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.
If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoodinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

*Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).*
TTY: 711

To access language services at no cost to you, call 1-877-261-8403.

Para acceder a los servicios de idiomas sin costo, llame al 1-877-261-8403. (Spanish)

如欲使用免費語言服務，請致電 1-877-261-8403。 (Chinese)

Afin d'acceder aux services langagiers sans frais, composez le 1-877-261-8403. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-877-261-8403. (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-877-261-8403 an. (German)

(حجز للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 480-1-877.)

Pou jwenn sèvis lang gratis, rele 1-877-261-8403. (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-877-261-8403. (Italian)

言語サービスを無料でご利用いただくには、1-877-261-8403 までお電話ください。 (Japanese)

무료 언어 서비스를 이용하려면 1-877-261-8403 번으로 전화해 주십시오. (Korean)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 340-1-877-261 تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonić 1-877-261-8403. (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-877-261-8403. (Portuguese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-877-261-8403. (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-877-261-8403. (Vietnamese)